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Issue date: 03Oct2001

CASE No.: 2000-BLA-00900

In the Matter of:

WAYNE HERB
Claimant

v.

KERRIS & HELFRICK, INC.,
Employer

and

LACKAWANNA CASUALTY COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-In–Interest

Appearances:

Helen M. Koschoff, Esquire
For the Claimant

A. Judd Woytek, Esquire
For the Employer
(Withdrew on August 23, 2001)
(No other counsel has entered an appearance)

Before: Ainsworth H. Brown
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS
ON MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq (the Act). The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

On June 23, 2000, the Director, Office of Workers' Compensation Programs referred this case to the Office of Administrative Law Judges for a formal hearing. DX-186. A hearing was held before me in Reading, Pennsylvania on February 21, 2001, at which time all parties were given a full opportunity to present evidence [1] and argument as provided in the Act and the Regulations issued thereunder, found at Title 20, Code of Federal Regulations.

ISSUES

Claimant has been credited with 18 years of qualifying coal mine employment. This issue is therefore not contested. TR 11. The following are at issue in this case, however:

(1) whether Claimant has pneumoconiosis;
(2) whether Claimant's pneumoconiosis arose out of coal mine employment;
(3) whether Claimant suffers from a totally disabling pulmonary or respiratory impairment;
(4) whether Claimant's total disability is due to pneumoconiosis;
(5) whether Claimant has established a mistake of fact or a change in condition[2]; and
(6) whether reopening this claim on modification would render justice under the Act.

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[1] The following references will be used herein: TR for transcript, CX for Claimant's exhibit, DX for Director's exhibit, and EX for Employer's exhibit.

[2] At the hearing, Director's exhibits 1 through 187 were admitted into evidence without objection. TR 5. Claimant's exhibits 1 through 17, 19, 20, 22 through 30 and 32 were admitted without objection. TR 6-7. Employer's exhibits 1 through 5, 8, 9, and 11 through 15 were admitted into evidence without objection. TR 10. Both Claimant and Employer were granted an enlargement of time to submit additional medical evidence post-hearing. TR 6-8, 20-21. Post-hearing, Claimant submitted CX-33 (Dr. Prince's review of 1-30-01 vent study) and CX-34 (Dr. Prince's review of 12-23-99 vent study). Claimant's exhibits 33 and 34 are admitted into evidence without objection. Post-hearing, Employer submitted EX-16 (medical report from Dr. Hertz) and EX-17 (curriculum vitae and invalidation report regarding 3-27-01 vent study). Employer's exhibits 16 and 17 are admitted into evidence without objection. Employer filed a post-hearing brief on August 23, 2001.

For the reasons stated herein, I find that Claimant has failed to establish entitlement to benefits on modification. Moreover, at the hearing, Claimant was instructed to provide specific argument regarding any alleged mistake in fact. TR 11. Said argument was to be submitted in writing on or before March 19, 2001. Since Claimant did not respond to the Court's Order or request additional time to provide said information, I find that Claimant has waived the "mistake of fact" argument.[3]

Claimant has failed to adduce *any* evidence that the previous denial of benefits constitutes a mistake in determination of fact or that the record supports a change in condition. I therefore conclude that reopening this claim on modification on the basis of a mistake in determination of fact would not render justice under the Act, and that Claimant has failed to establish a change in conditions.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Procedural History

Wayne Herb, Claimant, was born on August 17, 1922 . DX-1. He married Arlene (Jatko) Herb on April 6, 1946. DX-7, 96. He has no other dependents for purposes of augmentation of benefits under the Act.

While this case was pending a decision, new Federal Regulations were promulgated. Subsequently, there was litigation contesting their liability. On February 13, 2001, I issued an Order requiring the parties to submit a brief regarding the issue of whether specific regulations, i.e. 20 C.F.R. §§718.104(d), 718.201(a)(2). 718.201(c), 718.204(a), 718.205(c)(5) and 718.205(d), would affect the outcome of the current litigation. At the hearing on February 21, 2001, the parties agreed that the amended regulations would not affect the current litigation. TR 5. Moreover, in a brief dated March 15, 2001, the Director also agreed the amended regulations would not affect the current litigation. I concur with the aforementioned parties and find that the amended regulations will not affect the outcome of this case. The District Court has now ruled the regulations valid.

This claim has an extensive procedural history. Claimant filed his first claim for black lung benefits on June 28, 1973. DX-96. The claim was denied by the Department of Health, Education and Welfare on August 1, 1973 and June 14, 1979, and by the District Director on January 15, 1981. DX-96.

[3]To avoid any second guessing I will proceed with a discussion of the issue.

Claimant filed his second claim for benefits on July 11, 1984.[4] DX-1. The claim was denied by the District Director on September 19, 1984. DX-15. The claim was then transferred to Administrative Law Judge Reid C. Tait on February 4, 1987 for review. DX-42. On September 4, 1987, Judge Tait issued a Decision and Order finding Claimant established 18 years of coal mine employment but that he failed to establish the existence of pneumoconiosis. DX-49. Claimant appealed the denial to the Benefits Review Board (the "Board") but thereafter requested a Modification on August 1, 1988. DX-51. The Board granted the Claimant's Request for Modification and remanded the claim on December 30, 1988. DX-59. Modification was denied by the District Director on June 14, 1989. DX-64. A hearing was subsequently held before me on October 16, 1990. DX-74. On April 16, 1991, I issued a Decision and Order Denying Benefits. DX-81. Claimant appealed to the Board. On May 28, 1993, the Board remanded the claim to me for further consideration. DX-83. On January 16, 1996, I issued a Decision and Order on Remand Denying Benefits. DX-87. Claimant requested modification of his claim on November 14, 1996. DX-88. Said claim was denied by the District Director on February 3, 1997. DX-93. The parties agreed to waive a formal hearing before an Administrative Law Judge and have the claim decided on the evidence in the record. On April 26, 1999, I issued a Decision and Order Denying Benefits on Modification. Once again, I found that Claimant had failed to establish the existence of pneumoconiosis, mistake of fact, or a material change in condition. DX-161. Claimant appealed but then filed a Motion to Remand to pursue Modification that was granted by the Board on August 13, 1999. DX-171. Claimant's request for Modification was denied by the District Director on March 1, 2000. DX-183.

At the hearing, Claimant testified he was 78 years old. TR 13. Since his previous testimony on October 16, 1990 his breathing had gotten worse. Claimant stated he could only walk a half of one block or walk up five to six steps before becoming "winded." TR 14. In addition he sleeps with two pillows at night to help his breathing. TR 14. Claimant added he has not smoked since 1962. TR 14. He testified he continued to treat with Drs. Raymond and Matthew Kraynak every two months for his breathing problem. TR 15. He had been treating with Dr. Raymond Kraynak for twelve years. TR 15. Claimant saw Dr. Kruk twice in the last fifteen years. TR 17. Claimant testified he did not have any heart problems and that hot humid weather caused his breathing to become worse. TR 16. Claimant was on an inhaler, Serevent. TR 16. Claimant denied having diabetes or high blood pressure. TR 19. Claimant admitted smoking one pack of cigarettes per day for eighteen years, but had not smoked since 1962. TR 19. Claimant had not been hospitalized in the last five years. TR 20.

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[4] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because Claimant's last exposure to coal mine dust occurred in the Commonwealth of Pennsylvania this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Third Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

Standard for Modification

> Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that
>
> Upon his own initiative, or upon the application of any party … on the ground of a change in conditions or because of a mistake in a determination of fact … the [fact-finder] may, at any time … prior to one year after the rejection of a claim, review a compensation case …

33 U.S.C. §922, as incorporated by 30 U.S.C. §932(a) and implemented by 20 C.F.R. §725.310.

Section 22 provides the sole avenue for changing otherwise final decisions on a claim. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291, 295 (1995)(*Rambo I*); *Kinlaw v. Stevens Shipping and Terminal Co.*, 33 BRBS 68 (1999), *aff'd*., No. 99-1954, 2000 U.S.App. LEXIS 31354 (4th Cir. April 5, 2000).

Judicial authority requires a broad reading of Section 22, and neither the wording of the statute nor its legislative history supports a "narrowly technical and impractical construction." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 255 (1971); *Branham v. Beth Energy Mines, Inc.*, 20 BLR 1-27, 1-31-33 (1996). Given its liberal application, it is clear that the petition seeking modification need not allege any specific ground or relief. *See Keating v. Director, OWCP*, 71 F.3d 1118, 1123, 20 BLR 2-53 (3d Cir. 1995); *Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993); *accord Consolidation Coal Co. v. Worrell*, 27 F.3d 227, 18 BLR 2-290 (6th Cir. 1994); *see generally Fireman's Fund Insurance Co. v. Bergeron*, 493 F.2d 545, 547 (5th Cir. 1974); H.Rep.No. 1244, 73d Cong., 2d Sess. 4 (1934).

While the modification procedure, and the adjudicator's authority to reopen the claim, is "easily invoked," *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497, 22 BLR 2-1 (4th Cir. 1999) (*Stanley*), the decision whether to grant modification on the basis of a mistake in determination of fact is committed to the adjudicator's discretion. *See Kinlaw*, 2000 U.S.App. LEXIS 31354 at *8-10, *aff'g* 33 BRBS 68 (1999); *see also Duran v. Interport Maintenance Co.*, 27 BRBS 8,14 (1993) (Board reviews Section 22 findings under abuse of discretion standard). This is not to say that an administrative law judge or district director may simply deny a petition for modification on a whim. To do so would constitute an abuse of discretion as being arbitrary and capricious and unwarranted by the record.

The adjudicator must examine the record as a whole, *see Keating*, 71 F.3d at 1123, 20 BLR 2-53, render findings which must be supported by substantial evidence, and articulate a rationale for its decision, even though the decision on whether to reopen a claim is committed to its discretion. Indeed, the adjudicator "has the authority, *if not the duty*, to reconsider all the evidence for any mistake of fact or change in condition," *Worrell*, 27 F.3d at 230, 18 BLR 2-290 (emphasis added); *see Jessee*, 5

F.3d at 726, 18 BLR 2-26 (deputy commissioner "must" review request for modification), by examining "wholly new evidence, cumulative evidence, or merely [by] further reflection on the evidence initially submitted." Moreover, if the evidence establishes that a claimant's condition has worsened, modification will be appropriate because a claimant "should receive his benefits if and when he becomes entitled to them." *Stanley*, 194 F.3d at 500 n.4, 22 BLR 2-1.

In every instance, the party who seeks to reopen a claim on modification bears the burden of proof. *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 138-39 (1997) (*Rambo II*); *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 736, 17 BLR 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

With this in mind, I turn to the merits of Claimant's Request for Modification. While this decision is based on a *de novo* review and consideration of the administrative record as a whole, not all of the evidence that has been introduced prior to the instant request for modification, and has been set forth in the prior Decisions, may again be listed except as required for an analysis of the current request for modification. *See generally Wheeler v. Apfel*, 224 F.3d 891, 895 n.3 (8th Cir. 2000).

Further, given the progressive nature of pneumoconiosis, *see Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250, 258 (4th Cir. 2000), the more recent evidence with respect to the nature and extent of Claimant's pulmonary or respiratory disability would be the more probative of his condition at the time of the hearing. *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 11 BLR 2-147 (6th Cir. 1988); *see also Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985).

Entitlement to Benefits: In General

Entitlement to benefits depends upon proof of three elements: in general, a miner must prove that: 1) he has pneumoconiosis which 2) arose out of his coal mine employment and 3) is totally disabling. Failure to prove any of these requisite elements precludes a finding of entitlement. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986)(en banc). Because Claimant has previously failed to establish any of the foregoing elements, I must review the record as a whole to determine whether he has proven that he has pneumoconiosis, 20 C.F.R. §718.202, which arose out of his coal mine employment, 20 C.F.R. §718.203, that he is totally disabled, 20 C.F.R. §718.204(c); *see Carson v. Westmoreland Coal Company*, 19 BLR 1-16 (1994), *modified on recon.* 20 BLR 1-64 (1996); *see also Beatty v. Danri Corp.*, 49 F.3d 993, 19 BLR 2-136 (3d Cir. 1995), and whether pneumoconiosis is a substantial contributor to any total pulmonary or respiratory disability. 20 C.F.R. §718.204(b); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 BLR 2-23 (3d Cir. 1989).

Entitlement:: Determination of Pneumoconiosis

Claimant must first establish the presence of pneumoconiosis. Pursuant to §718.202, a living miner can demonstrate pneumoconiosis by means of: (1) x-rays

interpreted as being positive for the disease; or (2) biopsy evidence; or (3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concludes presence of the disease, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical exams, and medical and work histories.

The Third Circuit, under whose jurisdiction this case arose, held that all of the relevant evidence relating to pneumoconiosis under §§718.202(a)(1-4) must then be weighed together to determine whether the claimant has established the existence of pneumoconiosis by a preponderance of the evidence. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25, 21 B.L.R. 2-104 (3rd Cir. 1997).

a. Chest X-ray Evidence

Chest x-ray interpretations were submitted into evidence which are relevant to the determination of whether Claimant has pneumoconiosis. The following is a listing of the admissible x-ray readings, together with the names and qualifications of the interpreting physicians[5]:

Date	Exhibit	Doctor	Rereading	Conclusion
10-15-80	DX-96	Peralta, BCR	10-15-80	1/1, p
10-15-80	DX-96	Singzon	10-16-80	p-1
10-15-80	DX-96	Gordonson, BCR,B	11-11-80	0/0
10-15-80	DX-27	Laucks, BCR,B	8-25-86	0/0
10-15-80	DX-27	Dessen, BCR,B	8-25-86	0/0
3-15-82	DX-36	Shoop	3-16-82	Normal
8-14-84	DX-13	Conrad, BCR	8-20-84	1/0, p,p
8-14-84	DX-12	Greene, BCR,B	9-9-84	0/0
8-14-84	DX-27	Laucks, BCR,B	8-25-86	0/0
8-14-84	DX-27	Dessen, BCR,B	8-25-86	0/0
2-22-85	DX-44	Tilva	2-22-85	oval density noted, otherwise normal
12-17-86	DX-29	Mathur, BCR,B	12-23-86	2/2, p,q 6 zones
12-17-86	DX-35,57,62	Laucks, BCR,B	12-17-87	0/0
2-6-87	DX-43,48,76	Laucks, BCR,B	2-6-87, 9-20-90	0/0
2-6-87	DX-76	Sundheim, BCR,B	10-8-90	0/0

[5] The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

9-12-90	DX-76	Laucks, BCR,B	9-20-90	0/0
9-12-90	DX-76	Sundheim, BCR,B	10-8-90	0/0
9-12-90	DX-78	Kibelstis, BCI	1-11-91	0/0
9-12-90	DX-79	Mathur, BCR,B	2-1-91	1/1, p,s, 6 zones
9-12-90	DX-80	Marks, BCR,B	2-9-91	½, s,t, 4 zones
9-13-90	DX-73	Mathur, BCR,B	9-15-90	1/1,p,s, 6 zones
9-13-90	DX-76	Laucks, BCR,B	10-19-90	0/0
9-13-90	DX-76	Kibelstis, BCI	11-12-90	0/0
9-13-90	DX-76	Sundheim, BCR,B	11-27-90	0/0
2-13-96	DX-88	Smith, BCR,B	3-8-96	1/1, p,s, 6 zones
2-13-96	DX-98	Mathur, BCR,B	10-15-97	1/1, p,s, 4 zones
2-13-96	DX-140	Marshall, BCR,B	6-15-98	1/1, q,p, 6 zones
2-13-96	DX-141	Gayler, BCR,B	7-15-98	0/0
2-13-96	DX-141	Wheeler, BCR,B	7-16-98	0/0
2-13-96	DX-141	Scott, BCR,B	7-21-98	0/0
9-5-97	DX-126	Ciotola, BCR,B	9-7-97	0/0
9-5-97	DX-127	Goodman, BCR,B	9-22-97	0/0
9-5-97	DX-100,101	Cappiello, BCR,B	1-11-98	1/1, p,q, 6 zones
9-5-97	DX-141	Laucks, BCR,B	7-9-98	0/0
9-5-97	DX-141	Duncan, BCR,B	7-9-98	0/0
9-5-97	DX-141	Soble, BCR,B	7-14-98	0/0
9-5-97	DX-107, 108	Ahmed, BCR,B	12-21-98	1/1, p,p, 6 zones
9-5-97	DX-102,103	Miller, BCR,B	12-30-98	1/0, p,s, 6 zones
4-7-00	EX-1	Wheeler, BCR,B	5-17-00	0/0
4-7-00	EX-2	Scott, BCR,B	5-17-00	0/0
4-7-00	CX-14	Miller, BCR,B	10-12-00	1/1, p,q, 6 zones
4-7-00	CX-16	Cappiello, BCR,B	10-20-00	1/1, p,q, 6 zones

Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.202(a)(1). The interpretations of dually qualified physicians are entitled to more weight than the interpretations of B-readers. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(*unpublished*).

Overall, there are forty-two (42) interpretations of eleven (11) x-rays in the record. Of the forty-two (42) interpretations, twenty-seven (27) were negative and fifteen (15) were positive for pneumoconiosis. There are twenty-three (23) negative interpretations that have been rendered by Board-Certified Radiologists and B-readers. Twelve (12) positive interpretations were rendered by dually qualified physicians. Based on the foregoing, it is clear that the probative negative interpretations overwhelmingly outweigh the probative positive interpretations. However, an administrative law judge is not required to simply defer to a bare “numerical superiority” of x-rays. *Wilt v. Wolverine Mining Co.*, 14 BLR 1-70 (1990).

It is proper to accord more weight to the more recent x-ray films of record. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-49 (1989) (en banc).

The record contains two (2) negative interpretations and two (2) positive interpretations of the recent x-ray of 4-7-00. All of the interpretations were by dually qualified physicians.

I accord more weight to the interpretations of the dually qualified Board-Certified Radiologists and B-readers. However, the most recent x-ray evidence is evenly divided between Claimant and Employer (i.e. 2 positive interpretations and 2 negative interpretations by dually qualified physicians). In *Director, OWCP v. Greenwich Collieries*, 114 S.Ct. 2251 (1994), *aff'g. sub. nom., Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993), the United States Supreme Court dispensed with the "true doubt" rule thereby requiring claimants to establish the requisite elements of entitlement by a preponderance of the evidence. Accordingly, since the most recent evidence is evenly divided between the Claimant and Employer, I find that Claimant has failed to prove by the preponderance of the evidence the existence of pneumoconiosis by x-ray evidence.

b. Biopsy Evidence

Pursuant to §718.202(a)(2) Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, it is clear that pneumoconiosis has not been established in this manner.

c. The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions provided in §§718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the §718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the §718.306 presumption because he is still living. Moreover Claimant is ineligible for the §718.304 presumption as there is no evidence that Claimant suffers from complicated pneumoconiosis.

Based on the foregoing, it is clear Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202(a)(3).

d. Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion. Of record are the opinions of Drs. Singzon, Karlavage, Raymond Kraynak, Kruk, Dittman, Matthew Kraynak, and Hertz.

The medical report of Dr. J. Singzon, whose qualifications are not of record, is dated October 24, 1980. DX-96. He noted a family history of high blood pressure, heart disease, diabetes, and cancer. Claimant reported a history of pneumonia, attacks of wheezing, bronchial asthma, arthritis, and heart disease. Dr. Singzon noted a 30-pack-year smoking history ending in 1969. Claimant's current symptoms included cough, wheezing, mild exertional dyspnea, and chest pain. Physical examination was unremarkable. Dr. Singzon diagnosed Claimant as having coronary artery disease with angina. He added that Claimant had no significant pulmonary disease related to coal dust exposure.

The medical report of Dr. J. J. Karlavage, whose qualifications are not of record, is dated August 9, 1984. DX-10. He noted a family history of high blood pressure, heart disease, diabetes, and cancer. Claimant reported a history of pneumonia, attacks of wheezing, bronchial asthma, and heart disease. Dr. Karlavage noted a 30-pack-year smoking history ending in 1970. Claimant's current symptoms included cough, sputum production, wheezing, dyspnea, and chest pain. Physical examination was unremarkable. Dr. Karlavage diagnosed Claimant as having anthracosilicosis due to coal dust exposure.

The first medical report of Dr. Raymond Kraynak, who is Board-Eligible in Family Medicine, is dated January 20, 1987. DX-39. Dr. Kraynak noted Claimant had been under his care since December 17, 1986 (less than one month). He noted Claimant complained of exertional dyspnea and productive cough. He added Claimant had difficulty walking one to two blocks or up one flight of steps without becoming short of breath. He noted a smoking history of 10-pack-years ending in 1960. He reviewed Claimant's occupational history and noted eighteen years of coal mine employment, all above ground. He noted Claimant stopped working in 1984 secondary to a strike. Dr. Kraynak reviewed several x-ray interpretations that were all positive for pneumoconiosis. He also reviewed the results of several pulmonary function studies and a blood gas study. Physical examination revealed a person in mild respiratory distress with cyanotic lips. Dr. Kraynak also noted a mild increase in the AP diameter with scattered wheezes in all lung fields. Dr. Kraynak concluded based on eighteen years of coal mine employment, complaints presented, lack of other disabling medical conditions, physical examination, and diagnostic studies performed that Claimant was completely and permanently disabled secondary to anthracosilicosis contracted during his employment in the coal industry.

The deposition of Dr. Kraynak was taken on February 27, 1987. DX-45. Dr. Kraynak reiterated his findings and conclusions contained within his report.

The medical report of Dr. Stephen Kruk, who is Board-Certified in Internal Medicine, is dated February 27, 1987. DX-56. He noted Claimant worked in the coal industry for eighteen years (1966 to 1984). Claimant complained of progressively worse shortness of breath for 5 to 6 years, chronic morning cough productive of dark sputum, and two-pillow orthopnea. He noted a smoking history of one pack per day until 1962. Physical examination was unremarkable. He reviewed a pulmonary function study

performed that day and noted a combined obstructive and restrictive defect with moderate restriction and mild obstruction. He reviewed the 12-17-86 chest x-ray interpretation of Dr. Mathur that showed 2/2, p/q, 6 zones. A stress test was also performed to rule out a cardiac source of his breathing difficulties. Dr. Kruk concluded that Claimant suffered from pneumoconiosis and severe disability based on his chest x-ray, stress test, and pulmonary function test. He noted there was no evidence of a cardiac etiology. He considered Claimant's years of employment in the coal industry as being responsible for his condition.

The medical report of Dr. Thomas Dittman, who is Board-Certified in Internal Medicine, is dated March 11, 1987. DX-48. Claimant's chief complaint was problems with his breathing for the last five to six years. Claimant reported having dyspnea on exertion walking two blocks or when climbing one flight of steps. He coughed daily and produced some sputum. He reported that he sleeps with two pillows. Claimant was on Xanax and Brondecon. Dr. Dittman noted that Claimant worked in the surface coal mining industry from 1966 to 1984. He noted a smoking history of one pack per day from 1940 to 1962. Dr. Dittman reviewed Claimant's family medical history. Physical examination was unremarkable. An EKG showed normal sinus rhythm and arterial blood gases showed normal oxygenation and compensated metabolic acidosis. Pulmonary function study was invalid due to inconsistent effort and poor cooperation of Claimant from trial to trial. A chest x-ray read by Dr. Laucks was negative for pneumoconiosis. Dr. Dittman concluded based on his normal physical examination, essentially normal arterial blood gases, and negative chest x-ray, Claimant did not have pneumoconiosis and he was not physically impaired or disabled on the basis of this entity.

The deposition of Dr. Dittman was taken on March 26, 1987. DX-46. Dr. Dittman reiterated his findings and conclusions contained within his report.

The second report of Dr. Dittman is dated September 19, 1990. DX-75. He reviewed Claimant's past medical history, medications, social history, occupational history, and family history. Claimant's chief complaint was "shortness of breath" for eight to ten years. He also complained of a daily cough productive of some sputum. Claimant complained of hemoptysis three to four times over the past two years and two-pillow orthopnea. Claimant also noted having chest pain, or tightness, in the lower anterior sternal area for the past two years. Physical examination was unremarkable. An EKG showed sinus tachycardia with no acute ST-T wave abnormalities. Arterial blood gases were performed only at rest due to Claimant's chest pain. Pulmonary function testing was attempted but several of the tracings demonstrated interrupted flow and inconsistent effort. Claimant was referred to Hazleton General Hospital for pulmonary function testing. Once again those tracings demonstrated hesitant flow, interrupted flow and inconsistent effort. Interpreting the best set of tracings, Dr. Dittman concluded they showed a severe obstructive defect without improvement after administration of the bronchodilators. He added that this interpretation had to be considered in light of Claimant's poor effort. A chest x-ray interpreted by Dr. Laucks was still pending at the time of the report. Dr. Dittman concluded that if the chest x-ray

were positive for pneumoconiosis, based on the normal arterial blood gases and physical examination, Claimant would not be severely impaired or disabled by the pneumoconiosis. If the chest x-ray was negative, then it would be Dr. Dittman's opinion that Claimant did not have pneumoconiosis and would not be physically impaired or disabled on the basis of that disease entity. Dr. Dittman also diagnosed Claimant as having angina pectoris.

The deposition of Dr. Dittman was taken on November 5, 1990. DX-76. Dr. Dittman reiterated his findings and conclusions contained within his report. He noted that a chest x-ray was interpreted by Dr. Laucks, a Board-Certified radiologist and B-reader, as negative for pneumoconiosis. TR 13. Based on Claimant's history, the diagnostic tests, and physical examination, Dr. Dittman concluded Claimant did not have pneumoconiosis and that he was not impaired or disabled on the basis of pneumoconiosis. TR 21-22. Dr. Dittman added that Claimant did not suffer from a pulmonary disease, he did not have pneumoconiosis, and he was not disabled. TR 23-24. Dr. Dittman also stated that Claimant's condition had not worsened since his first examination in 1987. TR 25.

The deposition of Dr. Raymond Kraynak was taken on December 12, 1990. DX-77. He testified that Claimant complained of shortness of breath, productive cough, and difficulty walking one to two blocks or up one flight of steps before becoming short of breath. TR 4. Dr. Kraynak stated that Claimant's physical examination revealed a person who looked older than his stated age and that he had cyanotic lips. Dr. Kraynak also noted an increase in the AP diameter with scattered wheezes. TR 6. He reviewed a chest x-ray dated 9-13-90 that was interpreted by Dr. Mathur as positive for pneumoconiosis. He reviewed the results of pulmonary function testing performed on 7-9-90, 7-30-90, and 9-12-90. TR 8-12. Dr. Kraynak concluded based on eighteen years of coal mine employment, complaints presented, lack of other disabling medical condition, physical examination, and diagnostic studies performed that Claimant was completely and permanently disabled secondary to anthracosilicosis contracted during his employment in the coal industry. TR 12. Dr. Kraynak admitted on cross-examination that there were several BCR-B readings of the 9-13-90 that were negative for pneumoconiosis.

The second report of Dr. Kraynak is dated November 20, 1996. DX-92. He noted that Claimant had been under his care and that he remained totally disabled. He added that Claimant had a pulmonary function study on 2-13-96 that showed an FEV-1 of 56%, FVC of 56%, and an MVV of 50%. Dr. Kraynak stated that Claimant had had a worsening of his complaints and condition.

The third report of Dr. Dittman is dated September 17, 1997. DX-128. At that time Claimant was 75 years old and his chief complaint was that his breathing was worse. He complained of dyspnea on exertion when walking ½ block on the level or up 10 steps. He continued to complain of a cough productive of sputum and two-pillow orthopnea. He also described a sensation of chest tightness with exertion. Once again Dr. Dittman reviewed Claimant's past medical history, medications, social history,

occupational history and family medical history. Physical examination was unremarkable. An EKG showed normal sinus rhythm. Arterial blood gases were normal and a chest x-ray read by Dr. Ciotola was negative for pneumoconiosis. Pulmonary function studies were unreliable due to Claimant's inconsistent and poor effort but otherwise showed a moderate restrictive defect. Dr. Dittman concluded, based on normal physical examination, normal arterial blood gases, and negative chest x-ray, that Claimant did not have pneumoconiosis and was not physically impaired or disabled on the basis of pneumoconiosis. He also diagnosed Claimant as having aortic stenosis, atherosclerotic vascular disease, and angina pectoris.

The deposition of Dr. Raymond Kraynak was taken on May 22, 1998. DX-109. He testified that Claimant complained of shortness of breath, productive cough, difficulty walking ½ block or up several steps without stopping to regain breath. TR 4. Dr. Kraynak stated Claimant's respiratory complaints have gotten progressively worse. He noted that physical examination of Claimant revealed a man who looked older than his stated age, cyanotic lips, and lungs showed scattered wheezes. Dr. Kraynak reviewed various pulmonary function tests, arterial blood gases, and chest x-rays. Dr. Kraynak concluded Claimant was completely and permanently disabled secondary to anthracosilicosis contracted during his employment in the coal industry. TR 13. On cross-examination, Dr. Kraynak admitted that the values obtained in the 2-13-96 pulmonary function study were higher than those obtained in the study performed on 2-19-86. TR 15. His file also contained a report from Dr. Singzon in 1980 who diagnosed Claimant as having coronary artery disease with angina. TR 16.

The deposition of Dr. Dittman was taken on June 12, 1998. DX-139. He reiterated the conclusions and findings contained within his report. Dr. Dittman stated that even if Claimant were found to have pneumoconiosis he would not be disabled due to pneumoconiosis. TR 28.

In a brief note dated October 7, 1999, Dr. Kraynak stated that Claimant had been under his care for several years for coal worker's pneumoconiosis. He added that Claimant suffered from chronic shortness of breath, productive cough, and exertional dyspnea. Claimant would become short of breath walking ½ to one block or up several steps without stopping to rest. He concluded Claimant had suffered a worsening of his condition over time. DX-174.

The fourth report of Dr. Dittman is dated April 28, 2000. EX-3. At that time Claimant was 77 years old and his chief complaint was shortness of breath. He complained of dyspnea on exertion when walking one block on the level or up 6 to 8 steps. He complained of a dry cough that was occasionally productive of sputum. He also described some wheezing at times and a sensation of chest tightness with shortness of breath. Once again Dr. Dittman reviewed Claimant's past medical history, medications, social history, occupational history and family medical history. Physical examination was unremarkable. An EKG showed normal sinus rhythm. Arterial blood gases were normal and a chest x-ray read by Dr. Ciotola was negative for pneumoconiosis. Pulmonary function studies were unreliable due to Claimant's

inconsistent and poor effort but otherwise showed a mild obstructive defect. Dr. Dittman concluded, based on normal physical examination, normal arterial blood gases, and negative chest x-ray, that Claimant did not have pneumoconiosis and was not physically impaired or disabled on the basis of pneumoconiosis. He also diagnosed Claimant as having aortic stenosis, atherosclerotic vascular disease, and angina pectoris.

The fifth medical report of Dr. Dittman is dated July 12, 2000. EX-4. In this report Dr. Dittman reviewed additional medical records. Included in the records were notes from Dr. Francis Bobek dating from October 29, 1985 to January 6, 2000. There were some notations that Claimant suffered from intermittent troubles with cough, nasal congestion, chest congestion, sputum production and occasional wheezing. The lungs were usually described as clear although some wheezing was mentioned. Therapy prescribed, antibiotics, was that directed at an acute infectious process. Occasionally bronchodilators were used. There was no mention of a diagnosis of pneumoconiosis. Letters from internists to Dr. Bobek reveal treatment for colonic polyps with no mention of pneumoconiosis. Dr. Dittman reviewed records from a sleep research center that made no mention of pneumoconiosis or pulmonary problem. Chest x-rays from Bloomsburg Hospital dated 12-15-88 and 10-12-94 did not mention pneumoconiosis. Medical records from Sunbury Community Hospital from an admission on 4-24-97 for cataract extraction did not mention pneumoconiosis or any other pulmonary disorder. Records from an admission to Bloomsburg Hospital on 4-9-98 for colonoscopy did not mention pneumoconiosis or any other lung disease under Past Medical History. Records from Dr. Andrew Matragrano from the Department of Thoracic Medicine at Geisinger Medical Center reveal Claimant was being evaluated for sleep problems in November of 1988. Dr. Matragrano noted Claimant was under evaluation for Black Lung. Dr. Matragrano concluded Claimant suffered from three problems: insomnia, restless leg syndrome, and asthma. He did not make a diagnosis of pneumoconiosis. Dr. Dittman also reviewed records from the Rheumatology Department at Geisinger Medical Center where he was seen in September of 1999. He was diagnosed as having polymyalgia rheumatica. His past medical history was “not significant” and his lungs were described as clear.

Dr. Dittman stated that these additional medical records did not change in any way his opinion regard to Claimant’s condition. The medical records made no mention of pneumoconiosis or treatment of any ongoing chronic respiratory condition. Claimant did have occasional episodes of infectious bronchitis and Dr. Matragrano suggested the possibility of asthma. It was still Dr. Dittman’s opinion that Claimant did not have pneumoconiosis and was not disabled or impaired by pneumoconiosis.

The deposition of Dr. Dittman was taken on September 22, 2000. DX-14. Dr. Dittman reiterated the conclusions and findings contained within his reports dated April 28, 2000 and July 12, 2000. He noted that Claimant’s bouts with infectious bronchitis and possible asthma were not in any way related to Claimant’s coal mine employment. TR 29.

The second medical report of Dr. Stephen Kruk, who is Board-Certified in Internal Medicine, is dated January 17, 2001. CX-23. Claimant was 78 years old at the time of his examination. Claimant's chief complaint was shortness of breath for twenty years. Claimant could barely walk one block or one flight of steps because of shortness of breath. Claimant noted a small amount of sputum production in the morning and that weather did not affect his breathing. Claimant also complained of occasional paroxysmal nocturnal dyspnea and two-pillow orthopnea. Dr. Kruk noted a smoking history of one pack per day until the age of 35. Dr. Kruk noted Claimant's occupational history, social history, and medications. Physical examination was unremarkable, lungs were clear in all fields. Spirometry showed changes consistent with obstructive and restrictive defects. A 2-13-96 chest x-ray was read by Drs. Mathur and Smith as positive for pneumoconiosis. An EKG was unremarkable. Dr. Kruk concluded that Claimant was totally and permanently disabled secondary to pneumoconiosis based on eighteen years of exposure to coal dust, extreme dyspnea demonstrated on stress test with minimal exertion, chest x-ray, and spirometry.

The medical report of Dr. Raymond Kraynak is dated January 22, 2001. CX-27. He noted that Claimant had been under his care since 12-17-86. He noted Claimant complained of severe shortness of breath, exertional dyspnea, and productive cough. He added Claimant had difficulty walking ½ to one block or up several steps without becoming short of breath. He noted a smoking history of 20-pack-years ending in the 1960s. He reviewed Claimant's occupational history and noted thirteen years of coal mine employment, all above ground. He noted Claimant stopped working in 1984. Dr. Kraynak reviewed several x-ray interpretations that were all positive for pneumoconiosis. He also reviewed the results of a pulmonary function study performed on 6-6-00 that showed FEV-1 of 36%, FVC of 37%, and MVV of 33% of predicted. Physical examination revealed a 78 year old person who looked older than his stated age. Dr. Kraynak noted a mild increase in the AP diameter with scattered wheezes in all lung fields. Dr. Kraynak concluded based on ten plus years of coal mine employment, complaints presented, physical examination, and diagnostic studies performed that Claimant was completely and permanently disabled secondary to anthracosilicosis contracted during his employment in the coal industry.

The medical report of Dr. Matthew Kraynak, who is Board-Certified in Family Medicine, is dated January 23, 2001. CX-28. Dr. Kraynak noted he had evaluated Claimant on "several" occasions. He noted Claimant complained of severe shortness of breath, exertional dyspnea, and productive cough. He added Claimant had difficulty walking ½ to one block or up several steps without becoming short of breath. He noted a smoking history one pack per day from the 1940s ending in the 1960s. He reviewed Claimant's occupational history and noted thirteen years of coal mine employment, all above ground. He noted Claimant stopped working in 1984. Dr. Kraynak reviewed the 9-9-97 x-ray interpretation of Dr. Smith that was positive for pneumoconiosis. He also reviewed the results of a pulmonary function study performed on 3-27-00 that showed FEV-1 of 47%, FVC of 55%, and MVV of 42% of predicted. Physical examination revealed a 78 year old person who looked older than his stated age. Dr. Kraynak noted a mild increase in the AP diameter with scattered wheezes in all lung fields. Dr.

Kraynak concluded based on ten plus years of coal mine employment, complaints presented, physical examination, and diagnostic studies performed that Claimant was completely and permanently disabled secondary to anthracosilicosis contracted during his employment in the coal industry.

The deposition of Dr. Raymond Kraynak was taken on February 2, 2001. CX-32. Dr. Kraynak reiterated his findings and conclusions contained within his report of January 22, 2001. On cross-examination Dr. Kraynak indicated that he and Dr. Matthew Kraynak often keep separate files on the patients they see. TR 26. He did not have any notes in his file from Dr. Matthew Kraynak. TR 26. Dr. Kraynak was presented with a FAX from Claimant's attorney's office dated January 22, 2001. The message portion of the FAX stated, "Can Matt provide a full medical report similar to Dr. Ray's report which was faxed this date for revisions and per out [sic] telephone call." TR 28-29. Dr. Kraynak stated that the document speaks for itself. TR 29. Dr. Kraynak maintained that Claimant's condition had worsened over the last two years although he previously testified in 1998 that Claimant would experience dyspnea walking ½ block on the level. TR 33-35. He admitted that his examinations have found the same findings. TR 36.

The medical report of Dr. Jonathan Hertz is dated March 27, 2001. EX-16. Dr. Hertz is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. He is also a B-reader of chest x-rays. EX-17. Claimant was 78 years old at the time of his evaluation. He reported a smoking history of one pack per day for 15 years ending in 1966. Claimant complained of shortness of breath for 20 years. He could only walk ½ block or climb 5 to 6 steps before becoming short of breath. He also complained of a daily cough with small amounts of sputum production. He reported occasional wheezing. He currently was on Serevent inhaler. Dr. Hertz reviewed Claimant's occupational history, past medical history, and family history. Physical examination was unremarkable. Pulmonary function studies performed on 3-27-01 were irregular and sporadic and showed less than optimal effort by Claimant and were invalidation by Dr. Hertz. Dr. Hertz went on to summarize the most recent medical evidence of record. Dr. Hertz concluded based on history and physical examination and his review of the medical records that Claimant did not suffer from pneumoconiosis. Although, on physical examination, Claimant was unwilling to take a deep breath, he still did not hear any wheezing, rhonchi or crackles. There was no evidence of clubbing or cyanosis. Multiple chest x-ray reports showed no evidence of pneumoconiosis. Dr. Hertz also concluded Claimant was not disabled due to pneumoconiosis. Dr. Hertz added that the etiology of Claimant's shortness of breath was unclear but that he did have a positive family history for heart disease. He also added that Claimant was being treated for GERD that is a well-known cause of a myriad of chest symptoms including cough, phlegm, and wheezing. Dr. Hertz opined that GERD is likely an important factor with his symptom complaints.

Discussion

Out of the seven (7) physicians who have rendered an opinion in this matter, Drs. Singzon, Dittman, and Hertz concluded Claimant did not suffer from pneumoconiosis. Drs. Raymond Kraynak, Matthew Kraynak, Kruk, and Karlavage concluded Claimant did suffer from pneumoconiosis.

The point of departure in evaluating this evidence is the principle that the opinions of treating physicians are entitled to deference in the overall evaluation of the medical record. *See Mancia V. Director, OWCP*, 130 F.3d 579, 21 BLR 2-114 (3d Cir. 1997). As has been pointed out by the Third Circuit in a Social Security case, "[a] cardinal principle guiding … eligibility determinations is that the [administrative law judge] accord treating physicians' reports great weight, 'especially when their opinions reflect expert judgment based on a continuing observation of the patient's condition over a pronged period of time.'" *Morales v. Apfel*, 225 F.3d 310, 317 (3d Cir. 2000), *quoting Plummer v. Apfel*, 186 F.3d 422, 429 (3d Cir. 1999). Accordingly, I must bear in mind the deference that usually must be accorded the opinions of treating and examining medical experts, and will therefore view the medical opinions and professional judgments of Drs. Raymond and Matthew Kraynak with some indulgence.

I find the opinion of Dr. Dittman is entitled to greater weight as his reports are well-reasoned and well-documented. *Fields v. island Creek Coal Co.*, 10 BLR 1-19 (1987); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc). Dr. Dittman is Board-Certified in Internal Medicine. His practice involves the treatment of patients with pulmonary disease. Dr. Dittman examined Claimant four times since 1987. His reports are based on valid objective medical testing which showed predominately normal values and are supported by the x-ray evidence and the unremarkable physical examinations of Claimant. (see discussion of pulmonary function studies and arterial blood gases, infra).

Dr. Dittman's opinion is further supported by his supplemental medical record review. (see report July 12, 2000, EX-4). Dr. Dittman reviewed various medical records from medical providers unrelated to the current litigation dating from 1985 to 2000. In all of those records, no mention of pneumoconiosis was made as either a diagnosis or as part of Claimant's medical history. Dr. Dittman's opinion is also supported by the well-reasoned opinion of Dr. Singzon who also found that Claimant did not have pneumoconiosis .

Like Dr. Dittman, I find the opinion of Dr. Hertz to be well-reasoned and well-documented. Dr. Hertz is the most highly qualified physician to render an opinion in this case. *Burns v. Director, OWCP*, 7 BLR 1-597 (1984). He is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. Moreover, he is a B-reader of x-rays. Dr. Hertz examined Claimant and reviewed the relevant medical evidence including x-ray interpretations both positive and negative for pneumoconiosis, pulmonary function studies with invalidation and validation reports, medical reports by

other physicians, and arterial blood gases. Based on the totality of the information presented, Dr. Hertz concluded Claimant did not suffer from pneumoconiosis.

On the other hand, the opinions of Drs. Matthew[6] and Raymond Kraynak, Kruk and Karlavage are less credible. While Dr. Matthew Kraynak is Board-Certified in Family Medicine and Dr. Raymond Kraynak is Board-Eligible in Family Medicine, neither has an expertise in pulmonary medicine. Their reports are not well-reasoned and are based, in part, on invalidated vent studies (see discussion infra). Their abnormal findings on physical examination (i.e. cyanosis, wheezing) are not supported by any other physician and are contrary to every credible objective finding of record.

Likewise the medical reports of Drs. Kruk and Karlavage are not well-reasoned and should be given less weight. Dr. Kruk evaluated Claimant on two occasions. Apparently he was provided only positive interpretations of the chest x-rays. He based his diagnosis, in part, on the one-sided positive chest x-ray evidence although Claimant's physical examination was unremarkable and the lungs were clear in all fields. Dr. Karlavage diagnosed Claimant as having pneumoconiosis although his physical examination was unremarkable. Moreover, it is unclear from Dr. Karlavage's report what information he relied on in making his diagnosis. For these reasons, the opinions of Drs. Kruk and Karlavage should be given less weight.

Dr. Raymond Kraynak has been treating Claimant for many years. Claimant has testified to treating with Dr. Matthew Kraynak on several occasions. However, since the opinions of Drs. Kraynak are not well-reasoned or supported by objective medical evidence, they cannot be accorded additional weight. *Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997).

Based on the foregoing, I find Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202 (a)(4).

e. The Existence of Pneumoconiosis Pursuant to 20 C.F.R. 718.202(a)

I must now weigh all the relevant evidence under 718.202(a) in determining whether Claimant has established the existence of pneumoconiosis. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3d Cir. 1997).

As noted previously, I found that the preponderance of the evidence in the record does not establish the existence of pneumoconiosis pursuant to 718.202(a)(1) – (3). There were no autopsy or biopsy results in the record pursuant to 718.202(a)(2). In addition, none of the presumptions contained within 718.202(a)(3) were found to be applicable. Accordingly, the Claimant's chest x-rays pursuant to 718.202(a)(1) and the

[6] Employer, in his brief, alludes to the possibility that Dr. Matthew Kraynak may not have actually examined Claimant. (see Employer closing brief, page 8-9). Because Dr. Matthew Kraynak submitted a report that states to the contrary and since Claimant testified under oath at the hearing that he had seen Dr. Matthew Kraynak several times, I find Employer's insinuation to be without merit.

medical reports pursuant to 718.202(a)(4) are considered relevant evidence in making this determination.

After full evaluation of the evidence, I found in this opinion that Claimant failed to prove, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to §718.202(a)(1) that allows for the establishment of pneumoconiosis by chest x-ray. He also failed to establish pneumoconiosis pursuant to §718.202(a)(4) that allows for the establishment of pneumoconiosis through the well-reasoned medical report of a physician.

I further find, in weighing all of the relevant evidence together, that Claimant failed to establish the existence of pneumoconiosis by a preponderance of the evidence pursuant to 718.202(a). The well-reasoned opinions of Drs. Dittman and Hertz, supported by the credible objective evidence, outweigh the reports of Drs. Raymond Kraynak and Matthew Kraynak, Kruk and Karlavage.[7] Therefore, the Claimant has failed to establish by the preponderance of the evidence that he suffers from pneumoconiosis pursuant to 718.202(a).

Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. 718.203(a).

If Claimant had established the existence of pneumoconiosis, Employer indicated in his closing brief that they would concede that pneumoconiosis was due to Claimant's coal dust exposure. However, since Claimant was unable to establish the existence of pneumoconiosis, this element is moot.

Total Disability Due to Pneumoconiosis Pursuant to 718.204(b)

The finding of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. In making this determination, I must evaluate all relevant evidence. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). A claimant shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(c) standards shall establish claimant's total disability. *See Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986).

According to §718.204(c), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas test, 3) a diagnosis of cor pulmonale with right-sided congestive heart failure, and 4) a reasoned medical opinion concluding total pulmonary or respiratory disability. I must also consider claimant's testimony in all of the hearings to compare the medical opinion disability assessments

[7] see discussion above

against that testimony regarding the physical requirements of his usual coal mine work. *See generally Onderko v. Director, OWCP*, 14 BLR 1-2 (1988).

Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, accounting for sex, age, and height, produce a qualifying value for the FEV 1 test, plus either a qualifying value for the FVC test, or the MVV test, or a value of the FEV 1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV 1, FVC and the MVV test are measured results less than or equal to the values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718. *See Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n.5, 13 BLR 2-259 (3d Cir. 1990).

Assessment of the pulmonary function study results is dependent on the Claimant's height, which has been recorded between 67 and 68 inches. Considering this discrepancy, I find that Claimant's height is 67.8 inches for purposes of evaluating the pulmonary function studies. *See Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983).

The Secretary's regulations allow for the review of pulmonary function testing by experts who can review the ventilatory tracings and determine the validity of a particular test. 20 C.F.R. §718.103 and Part 718, Appendix B; *Siwiec*, *supra*; *see generally Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283, 11 BLR 2-80 (7th Cir. 1988). Thus, in assessing the probative value of a clinical study, an administrative law judge must address "valid contentions" raised by consultants who review such tests. *See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276, 18 BLR 2-42 (7th Cir. 1993); *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7th Cir. 1988); *Strako v. Ziegler Coal Co.*, 3 BLR 1-136 (1981); *also see Siegel v. Director, OWCP*, 8 BLR 1-156 (1985)(2-1 opinion with Brown, J., dissenting); *accord Winchester v. Director, OWCP*, 9 BLR 1-177 (1986).

The Third Circuit has emphasized that the administrative law judge "must determine whether the tests meet the quality standards and whether the medical evidence is reliable[.]" *Siwiec*, 894 F.2d at 638, 13 BLR 2-259.

The record includes the following pulmonary function study evidence:

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
DX-96	10-15-80	58	$67^{1/2}$	3.38	-----	150	-----	No

This test was performed at the direction of Dr. Singzon. Claimant's cooperation and comprehension were noted as good.

I find this study to be valid and conforming to the Regulations.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-9	8-13-84	61	67”	3.62	4.16	123	87%	No

Dr. Karlavage interpreted this test as being within normal limits. Claimant’s cooperation and comprehension were noted as good.

I find this study to be valid and conforming to the Regulations.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-37	12-17-86	64	68”	1.66	2.63	40	63%	Yes

Dr. Raymond Kraynak interpreted this test as sowing severe obstructive disease with restriction. Claimant’s cooperation and comprehension were noted as good.

Dr. Simelaro, who is Board-Certified in Internal Medicine, validated this study by checking a box on a form “vents are acceptable.” DX-37.

Dr. Levinson, who is Board-Certified in Internal Medicine and Pulmonary Disease, invalidated the study due to evidence that the FVC curves showed a degree of exhalation before exhalation was recorded on paper thus invalidating all three FVC curves. In addition, the MVV curves indicated a slow frequency of breathing that is not consistent with maximal effort. Moreover, the curves were variable. DX-31.

I will credit the highly qualified opinion of Dr. Levinson who is Board-Certified in Pulmonary Medicine over the opinion of Dr. Simelaro. It is clear from Dr. Levinson’s report that the results of the study were questionable due to the effort of Claimant.

Moreover, I attribute more weight to the opinion of Dr. Levinson who specifically identified a flaw in the study, i.e. Claimant’s lack of effort, as opposed to Dr. Simelaro who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Simelaro’s validation significant weight.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-30	12-19-86	64	$67^{3/4}$	1.47	1.75	75	84%	Yes

Dr. Raymond Kraynak interpreted this study as showing a severe obstructive disease with restriction. Claimant’s comprehension and cooperation were noted as “good.”

Dr. Levinson invalidated this study because all three of the FVC tracings were variable and inconsistent. Dr. Levinson described in detail how each curve was invalid. He also noted that the MVV curves were all invalid due to gross variability and inconsistency of effort. DX-32.

I find this test invalid on the basis of Dr. Levinson's qualifications and detailed explanation for the invalidation. *See Martinez, Dillon, Wetzel, supra.*

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-48	2-6-87	----	----	2.48	4.18	81	81%	No
				3.33	4.27	78	78%	

Dr. Dittman invalidated this test and noted it was without value due to poor cooperation and inconsistent effort on the part of Claimant.

Based on Dr. Dittman's highly qualified opinion I find this study to be unreliable as it does not conform to the quality standards set forth in the Regulations.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-56	2-11-87	64	68"	1.64	2.12	62	77%	No

This study was performed at Sunbury Community Hospital and was interpreted as showing a combined pulmonary disease with a major restrictive component.

This study was invalidated by Dr. Levinson because of unacceptable effort by Claimant. He noted excessive variability between the largest three FVC curves and the variation between the two largest FEV-1 curves was greater than 5%. Moreover, the only MVV curve provided was also invalid due to lack of consistent, sustained effort for 12 to 15 seconds as required. DX-58.

This study was also invalidated by Dr. McQuilen who agreed with the invalidation of Dr. Levinson. DX-63. He noted there was less than optimal effort, cooperation, and comprehension.

I find this test invalid on the basis of Dr. Levinson's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-51	2-16-87	64	68"	1.45	2.10	33	69%	Yes

Dr. Kruk interpreted this test as showing a moderate restriction and mild obstruction. Claimant's cooperation and comprehension were noted as good.

Dr. Levinson invalidated this study because of unacceptable effort by Claimant. He noted that the patient did not reach a full inspiration proceeding the forced expiration. The FEV-1 and FVC were falsely low because they did not represent the full expiratory effort. The MVV curves were invalid due to feeble effort. DX-58.

I find this test invalid on the basis of Dr. Levinson's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-72	7-9-90	67	68"	1.74	2.05	45	85%	Yes

Dr. Raymond Kraynak interpreted this test as showing a severe restrictive lung disease. Claimant's cooperation and comprehension were noted as good.

Dr. Venditto validated the study by checking a box on a form "vents acceptable." DX-72.

Dr. Levinson invalidated the study because the tracings did not contain the full exhalation of Claimant. It was impossible to determine the true and actual starting point of exhalation. Furthermore the MVV curves were variable and inconsistent.

I attribute more weight to the opinion of Dr. Levinson who specifically identified a flaw in the study, i.e. Claimant's lack of effort, as opposed to Dr. Venditto who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Venditto's validation significant weight. *Milburn Colliery Co. v. Hicks*, *supra*. Accordingly, I find this study to be unreliable.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-72	7-30-90	68	$67^{3/4}$	1.69	1.76	41	96%	Yes

This study was performed at the William H. Ressler Center and was interpreted as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as good.

Dr. Levinson invalidated the results of this study due to unacceptable effort by Claimant. There was excessive variability between the three FVC curves. Two of the largest FEV-1 curves varied by at least 300 ml which exceeded 5% of the largest FEV-1. The MVV curves were variable and inconsistent as well.

I find this test invalid on the basis of Dr. Levinson's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-75	9-12-90	68	68"	1.53	3.23	44	47%	Yes
				1.37	3.17	45	43%	Yes

This study was performed at Hazleton General Hospital. This test was interpreted by Dr. Dittman as showing a severe obstructive defect, but cautioned that this interpretation would have to be considered in light of Claimant's poor effort. He noted that the tracings showed hesitant flow, interrupted flow and inconsistent effort.

Dr. Kraynak validated the study by indicating that the tracings reflected good effort and that the technician noted good cooperation and comprehension. DX-77.

I find this test invalid on the basis of Dr. Dittman's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-88	2-13-96	73	68"	1.49	2.24	54	67%	Yes

This test was interpreted by Dr. Raymond Kraynak as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as good.

This test was invalidated by Dr. Michos, who is Board-Certified in Internal Medicine and is Board-Eligible in Pulmonary Medicine. He noted that he was unable to ascertain if a full inspiratory effort and expiratory effort was obtained when compared to prior pulmonary testing. Dr. Michos recommended repeat testing with flow volume loops. DX-90.

Dr. Kraynak responded to the invalidation by Dr. Michos and stated that the regulations allowed inspiration to be taken either from the machine or open atmosphere. If taken from the open atmosphere there would be no recording. He administered the test and attested to Claimant's inhalation. DX-98.

Dr. Dittman invalidated the study because he could not ascertain whether the maximum inhalation was taken at the beginning of testing and that the degree of plateau of the tracings was not extended long enough. DX-139.

I have carefully considered the rebuttal opinion of Dr. Raymond Kraynak. However, I find this test unreliable in view of the opinions of Drs. Michos and Dittman. I credit these consultants on the basis of their superior qualifications.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-98	6-12-97	74	68"	1.24	1.79	58	69%	Yes

This study was interpreted by Dr. Kraynak as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as good.

Dr. Dittman invalidated the study because of interrupted, hesitant flow during the tracing. The FVC maneuvers were inconsistent and the MVVs were performed with less than maximum effort. DX-139.

I find this test invalid on the basis of Dr. Dittman's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-98	6-23-97	74	$67^{1/2}$	.98	1.06	48	92%	Yes

This study was performed at the William H. Ressler Center and was interpreted by Dr. Kraynak as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as fair.

Dr. Dittman invalidated the study because of interrupted, hesitant flow during the tracing. The FVC maneuvers were inconsistent and the MVVs were performed with less than maximum effort. DX-139.

I find this test invalid on the basis of Dr. Dittman's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-128	9-5-97	75	68"	1.48	2.30	57	64%	Yes
				1.04	2.58	60	40%	Yes

This study was performed at Hazleton Hospital and was interpreted by Dr. Dittman as showing a moderate restrictive defect but cautioned that the patient's poor effort would need to be considered in evaluating this data. He noted that the test was inconsistent and showed a lack of maximum effort.

I find this test invalid on the basis of Dr. Dittman's qualifications and detailed explanation for the invalidation.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-182	9-23-99	77	67"	1.37	2.12	40	65%	Yes

This study was interpreted by Dr. Kraynak as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as good.

This study was invalidated by Dr. Kaplan, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. Dr. Kaplan noted that Claimant's effort was inconsistent, as demonstrated between the discrepancy between the actual and expected MVV. DX-176.

Dr. Kraynak responded to the invalidation by Dr. Kaplan by noting that the FVC and FEV-1 values were conforming. He acknowledged that the MVV was somewhat reduced but that it was the best effort Claimant could give. CX-10.

Dr. Kucera, who is Board-Certified in Pulmonary Disease, responded to the invalidation of Dr. Kaplan and stated that the test did not show excessive variability and that good effort was made. To use a predicted MVV from the actual FEV-1 was a good estimate of the actual MVV but the assumption has to be made there was no underlying chest wall diseases. In this case, that was not a valid assumption. DX-182.

Dr. Levinson also invalidated the study because the entire FVC curves were not displayed. Extrapolation of time zero indicated that the FEV-1 and FVC did not represent the true capacities of Claimant but were rather an underestimation. DX-181.

Dr. Kraynak responded to the invalidation by Dr. Levinson and stated that from his review the starting point of exhalation was listed by the zero point. The MVVs showed good effort and varied by less than 10% and continued for 12 seconds. CX-1.

Dr. Hertz invalidated the study as the tracings showed irregularity in the curves. This demonstrated that Claimant was not using maximal effort during the FVC. EX-9.

Dr. Kraynak responded to the invalidation of Dr. Hertz and stated the curves were regular and showed good effort. He also noted that Dr. Hertz did not make mention of the MVV which he maintained was valid and showed severe disability. CX-26.

This study was validated by Drs. Kucera (DX-179), Simelaro (CX-3), Venditto (CX-5), and Prince (CX-7) all of whom merely checked a box on a form "vents are acceptable."

I have carefully considered the rebuttal opinions of Dr. Kraynak. However, I find this test unreliable in view of the opinions of Drs. Kaplan, Hertz, and Levinson. I credit these consultants on the basis of their superior qualifications. Dr. Kucera, who is Board-Certified in Pulmonary Medicine, offered a rebuttal to Dr. Kaplan's invalidation but does not address the other issues raised by Drs. Hertz and Levinson. Accordingly, I find Dr. Kucera's opinion is outweighed by the opinions of Drs. Kaplan, Hertz and Levinson.

Moreover, I attribute more weight to the opinions of Drs. Kaplan, Hertz, and Levinson who specifically identified a flaw in the study, i.e. Claimant's lack of effort, as opposed to Drs. Prince, Kucera, Simelaro, and Venditto who merely validated the study by checking a box on a form. Without more explanation, I will not accord these validations significant weight. Accordingly, I find this study to be unreliable.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
CX-13	12-23-99	77	67"	1.11	1.58	40	70%	Yes

This study was interpreted by Dr. Raymond Kraynak as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as good.

Dr. Kaplan invalidated this study due to inconsistent effort by Claimant as evidenced by excessive variation and erratic contours found in the FVC tracings. EX-8.

Dr. Kraynak responded to the invalidation by Dr. Kaplan and noted there was good effort throughout and that any or all variations fall within the limits found in the Regulations. CX-29.

Dr. Hertz invalidated this study due to severe irregularity in the tracings which demonstrated less than maximal effort by claimant during the entire forced expiration. There was also an unsatisfactory start of expiration characterized by excessive hesitation. EX-9.

Dr. Kraynak responded to the invalidation by Dr. Hertz and noted the tracings were regular and showed good effort and that he did not detect an unsatisfactory effort at the start of exhalation. CX-26.

I have carefully considered the rebuttal opinions of Dr. Kraynak. However, I find this test unreliable in view of the opinions of Drs. Kaplan and Hertz. I credit these consultants on the basis of their superior qualifications.

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
CX-2	3-27-00	77	68”	1.18	2.14	44	56%	Yes

Dr. Matthew Kraynak interpreted this study as showing a severe restrictive defect. Claimant’s cooperation and comprehension were noted as good.

This study was invalidated by Dr. Levinson for several reasons. The study was improperly performed since the entire FVC curves were not displayed. There was evidence of exhalation before the zero point so that the reported FEV-1 and FVC were an underestimation of Claimant’s true capacity. There was excessive variability between the two largest FEV-1 curves. The FEV-1s varied by more than 650 ml which exceeded the Regulations indicating the FEV-1 should not vary by more than 100 ml or 5% of the largest FEV-1. There was only one MVV curve and that indicated a variable and inconsistent effort so that Claimant did not exert a maximal and sustained effort for 12 to 15 seconds as required. EX-5.

Dr. Matthew Kraynak responded to the invalidation by Dr. Levinson and noted he did not detect evidence of exhalation before the zero point, and noted Claimant’s effort was good. From his review the two largest FEV-1s varied by less than 90 ml corresponding to the Regulations. The entire FVC curves were displayed. There was only one MVV curve due to Claimant’s shortness of breath, and the tracings did continue for 12 seconds as required. CX-22.

Dr. Raymond Kraynak responded to the invalidation by Dr. Levinson and noted he did not detect evidence of exhalation before the zero point. From his review the two largest FEV-1s varied by less than 90 ml corresponding to the Regulations. The MVV curve continued for 12 seconds as required. CX-32.

Dr. Prince validated the study by checking a box in a form "vents acceptable." CX-34.

Dr. Dittman invalidated this study due to less than maximum effort on the FVC. There was hesitant flow and interrupted flow and the maximum exhalation does not begin at the onset of the tracing. There was only one MVV maneuver recorded on the tracing therefore it was an invalid study. EX-14.

Dr. Raymond Kraynak responded to the invalidation by Dr. Dittman and noted that he did not detect less than maximal effort on the FVC and that maximum exhalation began at the zero point. He maintained there were three tracings of the MVV not one. CX-32, page 22.

I have carefully considered the rebuttal opinions of Drs. Matthew and Raymond Kraynak. It is interesting to note that Drs. Levinson and Dittman stated there was only one MVV maneuver. Dr. Matthew Kraynak admitted in his rebuttal there was only one MVV maneuver due to Claimant's shortness of breath. Dr. Raymond Kraynak in his rebuttal to Dr. Dittman's invalidation maintained there were three MVV tracings which raises the question as to whether Dr. Raymond Kraynak actually reviewed the tracings. Nevertheless, I find this test unreliable in view of the opinions of Drs. Levinson and Dittman. I credit these consultants on the basis of their superior qualifications and well-reasoned opinions. Without more explanation, I will not accord the validation of Dr. Prince significant weight. Therefore, I find this study to be invalid.

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
EX-3	4-7-00	77	68"	1.87	3.35	41	56%	No
				1.98	2.96	54	67%	No

This study was performed at Hazleton General Hospital. Dr. Dittman interpreted this study as showing a mild obstructive defect without improvement after bronchodilator but noted that these results were not reliable to due inconsistent effort by Claimant.

Dr. Levinson invalidated this test due to unacceptable effort by Claimant. There was excessive variability of the FEV-1s that varied by 120 ml. Each FVC attempt indicated hesitancy in the onset of exhalation. The post-bronchodilator attempts were more variable as the FEV-1s varied by 560 ml. Claimant did not use maximal effort throughout the FVC attempt and there were multiple interruptions in the exhalation. The MVV attempts indicated a variable and inconsistent effort for a period of 10 seconds. EX-11.

Dr. Kaplan invalidated this test due to inconsistent effort by Claimant. Variation on the FVC curves exceeded that allowed by the Regulations. The discrepancy between the expected MVV and observed MVV was additional evidence of an inconsistent effort. EX-12.

Dr. Venditto invalidated the study because the best two tracings were not within 5% or 100 cc making it invalid. CX-13.

Dr. Simelaro invalidated the study because the best two tracings were not within 5% or 100 cc making it invalid. CX-20.

Dr. Raymond Kraynak invalidated the study due to gross variation in the flow loops indicating coughing or some technical problem. CX-32.

I will credit the foregoing invalidation reports as they are unanimous. Accordingly, I find this study to be unreliable.

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
CX-9	6-6-00	77	68”	.90	1.46	34	61%	Yes

This test was interpreted by Dr. Raymond Kraynak as showing a severe restrictive defect. Claimant’s cooperation and comprehension were noted as good.

This study was invalidated by Dr. Kaplan due to inconsistent effort by Claimant as evidenced by excessive variation and erratic contours found in the FVC tracings. EX-8.

Dr. Kraynak responded to the invalidation by Dr. Kaplan and noted there was good effort throughout and that any or all variations fall within the limits found in the Regulations. CX-29.

Dr. Hertz invalidated this study due to severe irregularity in the tracings which demonstrated less than maximal effort by claimant during the entire forced expiration. There was also an unsatisfactory start of expiration characterized by excessive hesitation. EX-9.

Dr. Raymond Kraynak responded to the invalidation by Dr. Hertz and stated the tracings were very regular and showed good effort throughout. He also noted exhalation began when it was supposed to start. CX-26.

I have carefully considered the rebuttal opinions of Dr. Kraynak. However, I find this test unreliable in view of the opinions of Drs. Kaplan and Hertz. I credit these consultants on the basis of their superior qualifications.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
CX-25	1-17-01	78	68”	1.03	1.95	35	53%	Yes
				1.02	2.02	26	51%	Yes

This study was interpreted by Dr. Kruk as showing obstructive and restrictive defects. Claimant’s cooperation and comprehension were noted as good.

This study was invalidated by Dr. Levinson because there was evidence of exhalation occurring before the zero point. The FEV-1s and FVCs were an underestimation of Claimant’s true capacity. The initial two seconds of the FVC approach a straight line rather than a parabolic curve indicating Claimant had not used maximal effort throughout the FVC attempt. The MVV curves indicated a variable and inconsistent effort for a period of only 10 ½ seconds. EX-13.
Dr. Raymond Kraynak reviewed the study and opined it conformed to the quality standards set forth in the Regulations. CX-32.

I have carefully considered the opinion of Dr. Kraynak. However, I find this test unreliable in view of the opinion of Dr. Levinson. I credit this consultant on the basis of his superior qualifications.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
CX-30	1-30-01	78	68”	1.08	1.96	30	55%	Yes
				1.12	2.24	35	50%	Yes

This study was interpreted by Dr. Matthew Kraynak as showing a severe restrictive defect. Claimant’s cooperation and comprehension were noted as good.

Dr. Levinson invalidated this study for several reasons. There was unacceptable effort by Claimant since there was hesitancy in the onset of exhalation. The MVV curves indicated a variable and inconsistent effort for a period of only 10 ½ seconds which is less than the 12 to 15 seconds required by the Regulations. EX-13.

Dr. Prince validated the study by checking a box a form “vents acceptable.” CX-33.

Dr. Raymond Kraynak reviewed the study and opined it conformed to the quality standards set forth in the Regulations. CX-32.

I have carefully considered the opinions of Drs. Kraynak. However, I find this test unreliable in view of the opinion of Dr. Levinson. I credit this consultant on the basis of his superior qualifications. Without more explanation, I will not accord the validation of Dr. Prince significant weight. Therefore, I find this study to be invalid.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
EX-16	3-27-01	78	68”	1.63	2.73	-----	60%	

1.06 1.89 ----- 56%

This study was performed at Lehigh Valley Hospital. Claimant's effort was noted as "consistently inconsistent" by the administering technician.

This study was invalidated by Dr. Hertz because of poor patient effort. He noted that the two largest FEV-1s varied by more than 100 cc and greater than 5%. Also the tracings were irregular and sporadic and demonstrated that Claimant did not use maximal effort during the entire forced expiration. EX-16, 17.

Based on the highly qualified opinion of Dr. Hertz, I find this study to be unreliable.

Discussion

Upon reviewing the pulmonary function study evidence of record, I find that Claimant has not demonstrated total respiratory disability at §718.204(c)(1) by a preponderance of the pulmonary function study evidence in the record as a whole.

Out of the twenty–two (22) pulmonary function studies in the record, only the first two studies, one from 1980 (DX-96) and one from 1984 (DX-9), are valid and conforming studies. These studies produced values that were non-qualifying and were within normal limits.

I find none of the remaining twenty (20) studies to be valid, conforming, and in substantial compliance with the regulations. Based on the foregoing, I find that all of the more recent studies have been invalidated by the well-reasoned opinions of highly qualified consultants. All of the credible consultants have based their opinions, at least in part, on the continuous lack of cooperation by Claimant in giving less than maximum effort. Because pulmonary function testing is an effort dependent test, I can not rely on any of the foregoing test results in forming an opinion regarding Claimant's respiratory capacity.

For these reasons I therefore find that Claimant has failed to demonstrate total respiratory disability on the basis of the pulmonary function study evidence.

Arterial Blood Gas Studies

A claimant may demonstrate total disability with arterial blood gas tests which, accounting for altitude, demonstrate qualifying results as specified in Appendix C to 20 C.F.R. Part 718. 20 C.F.R. §718.204(c)(2).

The current record contains the following blood gas studies:

Ex. No.	Date	Alt.	PCO2	pO2	Qual.
DX-96	10-15-80	----	38.8	77.5	No

DX-11	8-14-84	0-2999'	38	83	No
			33	69	No
DX-30	12-18-86	----	44.6	70.1	No
DX-48	3-6-87	----	30	89	No
DX-75	9-12-90	----	41.1	88	No
DX-128	9-5-97	----	33	87	No
EX-3	4-7-00	----	35	68.7	No

None of the arterial blood gas test results demonstrate total respiratory disability at Section 718.204(c)(2). I therefore find that Claimant has failed to demonstrate total respiratory disability on the basis of the blood gas study evidence.

Cor pulmonale

A claimant may demonstrate total disability with medical evidence of cor pulmonale with right-sided congestive heart failure in addition to pneumoconiosis. Because there is no evidence of cor pulmonale with right-sided congestive heart failure, I am unable to find that Claimant has demonstrated total disability at Section 718.204(c)(3). 20 C.F.R. §718.204(c)(3); *see Newell v. Freeman United Coal Mining Co.*, 13 BLR 1-37 (1989), *rev'd on other grounds*, 933 F.2d 510, 15 BLR 2-124 (7th Cir. 1991).

Medical Opinion Evidence

Claimant may demonstrate total respiratory disability by a reasoned medical opinion that assesses total respiratory disability, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. Claimant must prove his respiratory or pulmonary condition prevents him from engaging in his "usual coal mine employment or comparable and gainful employment." 20 C.F.R. §718.204(c)(4). Any loss in lung function may qualify as a total respiratory disability under Section 718.204(c). *See Carson*, 19 BLR at 1-21, *modified on recon.* 20 BLR 1-64 (1996).

There are seven (7) physicians who have rendered an opinion in this case. Drs. Raymond Kraynak, Matthew Kraynak, and Kruk opined Claimant suffered from a permanent, total respiratory disability that would prevent Claimant from engaging in his last mine employment. Drs. Dittman and Hertz opined Claimant maintained the respiratory capacity to perform his last coal mine employment.
Dr. Singzon indicated Claimant had no significant pulmonary disease related to coal dust exposure. Dr. Karlavage indicated Claimant suffered from pneumoconiosis but did not address whether Claimant had any respiratory disability, therefore his opinion will be given less weight on this issue.

Upon review of the medical opinion evidence as a whole, I find that Claimant has not met his burden of proving total pulmonary or respiratory disability at Section 718.204(c)(4). I am mindful of Dr. Raymond Kraynak and Dr. Matthew Kraynak's status as treating physicians. I nevertheless credit Dr. Hertz's most recent medical opinion,

that Claimant is not totally disabled, on the basis of his excellent credentials, the thoroughness of his report, and the clinical testing which forms some of the documentation in support of his conclusions. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269 (4th Cir. 1997); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc); *Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988). Moreover, Dr. Hertz's conclusions are supported by the well-reasoned, well-documented reports of Dr. Dittman who had the opportunity to exam Claimant on four separate occasions. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987).

I accord less weight to the reports of Drs. Raymond and Matthew Kraynak. Their reports are not well-reasoned and are not based on the credible evidence of record. They report physical findings, such as cyanotic lips and wheezing, that are not consistent with physical findings reported by other physicians of record. Their conclusions of disability are based, at least in part, on invalidated pulmonary function studies and non-qualifying arterial blood gases. For these reasons, I accord less weight to the foregoing opinions.

Although Dr. Kruk is Board-Certified in Internal Medicine, I find the qualifications of Dr. Hertz to be superior. Dr. Hertz is Board-Certified in Internal Medicine, Pulmonary Disease and Critical Medicine. He is an Assistant Professor of Medicine at Pennsylvania State University and has authored several articles pertaining to respiratory diseases. Moreover, I find Dr. Kruk's conclusions of total disability are based on unremarkable physical examinations, non-qualifying arterial blood gases, invalidated pulmonary function studies, and non-specific physical complaints by Claimant. Accordingly, I find the opinion of Dr. Kruk to be unsupported by the credible evidence of record and is entitled to less weight.

Reviewing the detailed findings and conclusions of Drs. Hertz and Dittman, I find that their opinions sufficiently undermine Claimant's case so that the medical opinion evidence does not persuasively demonstrate total respiratory disability at Section 718.204(c)(4).

Total Respiratory Disability

After evaluating like-kind evidence under each provision of section 718.204(c), I must then evaluate all relevant evidence at Section 718.202(c), like and unlike, to find whether Claimant has established total respiratory disability. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). Upon my consideration of all relevant evidence, like and unlike, including Claimant's testimony, see generally *Onderko v. Director, OWCP*, 14 BLR 1-2, 1-4 (1988); see also *Poole v. Freeman United Coal Mining Co.*, 897 F.2d 888, 894, 13 BLR 2-348 (7th Cir. 1990), I conclude that Claimant has not met his burden of establishing total disability.

I find that the non-qualifying arterial blood gas studies, the credible non-qualifying conforming pulmonary function studies, the most recent report from Dr. Hertz, which is detailed, comprehensive and corroborated by the earlier reports from Dr. Dittman

constitute “contrary probative evidence” which precludes a finding of total disability pursuant to Section 718.204(c). Again, I have accounted for multiple opinions from Claimant’s treating physicians. Nevertheless, I find, in the face of contrary probative evidence, that Claimant has failed to prove total respiratory disability by a preponderance of the evidence. Although Claimant need only establish total disability by a preponderance of the evidence, “the preponderance standard is not toothless.” *See United States v. Roman*, 121 F.3d 136, 141 (3d Cir. 1997), *cert. denied* 522 U.S. 1061 (1998).

Modification

I find, after a de novo review of the record as a whole, that Claimant has not proven that the prior determination, that he is not entitled to benefits, is mistaken. In the alternative, I also conclude, upon review of this evidence, especially the most recent medical reports and studies, that reopening this claim on the basis of the evidence filed in support of his request for modification would render justice under the Act. *See generally Hampton v. Cumberland Mountain Services Corp.*, BRB No. 99-0186 BLA (May 31, 2000)(unpub.) I am not persuaded that the extant record as a whole adequately supports the conclusion that Claimant’s condition is worsening so that an evolution in his condition militates against finality in this instance. I further conclude Claimant has failed to establish a change in conditions.

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(b). Claimant bears the burden of proving that pneumoconiosis is a substantial contributor to Claimant’s total respiratory disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 BLR 2-23 (3d Cir. 1989). In this case the record does not establish the existence of a totally disabling respiratory or pulmonary impairment. Assuming that Claimant had established total disability, I find that he has not convincingly established that pneumoconiosis is a substantial contributor to this total disability. Again, I credit the opinions of Drs. Hertz and Dittman that Claimant suffers from no pulmonary or respiratory impairment, on the basis of their superior credentials in the field of Internal Medicine and Pulmonary Disease.

Conclusion

Because Claimant has failed to prove any element of entitlement, I must conclude that he has failed to establish entitlement to benefits under the Act.

Order

The claim of Wayne Herb for benefits under the Act is hereby DENIED.

A

Ainsworth H. Brown
Administrative Law Judge

Attorney Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for services rendered to him in pursuit of this claim.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a Notice of Appeals with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.